

Case Name _____

Case Number _____

Child Protective Services Assessment for County of: _____

Assigned Social Worker: _____ Social Work Supervisor: _____

I. HOUSEHOLD / FAMILY COMPOSITION/ INDIVIDUAL CASE DECISION INFORMATION

a. Child full name / nickname	b. SIS # (11 digits)	c. Child's date of birth	d. Child's Race / Ethnicity	e. Child's sex	f. American Indian Heritage	g. Child's school / grade	h. Child's primary language	i. Child's status	j. Social Security Number
1.				<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
2.				<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
3.				<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
4.				<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
5.				<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
6.				<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	

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k. Adult full name / nickname	l. Relationship to child(ren)	m. Adult's date of birth	n. Adult's Race / Ethnicity	o. Adult's sex	p. American Indian Heritage	q. Adult's employer information	r. Adult's primary language	s. Is this adult a non- custodial parent?	t. Social Security Number
1.	<input type="checkbox"/> mother <input type="checkbox"/> father to ____ <input type="checkbox"/> other _____			<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> yes <input type="checkbox"/> no	
2.	<input type="checkbox"/> mother <input type="checkbox"/> father to ____ <input type="checkbox"/> other _____			<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> yes <input type="checkbox"/> no	
3.	<input type="checkbox"/> mother <input type="checkbox"/> father to ____ <input type="checkbox"/> other _____			<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> yes <input type="checkbox"/> no	
4.	<input type="checkbox"/> mother <input type="checkbox"/> father to ____ <input type="checkbox"/> other _____			<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> yes <input type="checkbox"/> no	
5.	<input type="checkbox"/> mother <input type="checkbox"/> father to ____ <input type="checkbox"/> other _____			<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> yes <input type="checkbox"/> no	
6.	<input type="checkbox"/> mother <input type="checkbox"/> father to ____ <input type="checkbox"/> other _____			<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> yes <input type="checkbox"/> no Tribe: _____			<input type="checkbox"/> yes <input type="checkbox"/> no	

1. Household physical address: _____

2. Household mailing address (if different than physical address): _____

3. Contact numbers: _____

4. Other information: _____

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II. CASE INFORMATION

1. Date of Original Report:

2. Date of Initiation:

3. Initiation Worker (if different than assigned worker):

4. Is this report an assist for another county? ☐YES ☐NO If yes, what county?

5. New report on this open assessment: ☐YES ☐NO ☐N/A
Explain: _____
6. If response method is switched, consultation with a supervisor is required.
Date: _____ Rationale: _____
7. Previous CPS record reviewed:
☐YES ☐NO ☐INFORMATION IN RECORD
8. Finding of Substantiation or Services Needed in the past year:
☐YES ☐NO ☐INFORMATION IN RECORD ☐N/A
If yes explain:

III. CIVIL / CRIMINAL RECORDS

(List / attach **relevant** information.)

1. [NCGS 50B](#) Order currently in place as per Administrative Office of the Courts (AOC):
☐YES ☐NO ☐INFORMATION IN RECORD
2. Civil Case Processing System (VCAP) check:
☐YES ☐NO ☐INFORMATION IN RECORD
3. Criminal history check for all persons **16 years of age or older** residing in the home per ACIS:
☐YES ☐NO ☐INFORMATION IN RECORD
4. 911 Response log reviewed:
☐YES ☐NO ☐INFORMATION IN RECORD

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IV. DILIGENT EFFORTS TO INITIATE CASE

List all attempts to make contact with the family.

a. Date	b. Time	c. Type of contact	d. Person contacted / relationship	e. Results of attempt to initiate
	am pm			
	am pm			
	am pm			
	am pm			
	am pm			
	am pm			
	am pm			
	am pm			
	am pm			

1. Referral initiated within the specified timeframe ☐YES ☐NO If no, consultation with a supervisor is required.

2. What was discussed during the initial contact?

3. If parent/caretaker was not contacted prior to the initiation, please explain.

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VI. CHILD AND FAMILY MEDICAL / WELL-BEING

This information is for the following family member(s): _____

1. When was child last seen by a medical provider for any reason including emergency room or hospitalization? _____
For what reason? _____
2. Primary medical provider: _____
Contact information: _____
Date of last appointment: _____
3. Dentist name: _____
Contact information: _____
Date of last appointment: _____
4. Therapist / psychiatrist name: _____
Contact information: _____
Date of last appointment: _____
5. Specialist name: _____
Contact information: _____
6. Place of birth (city, state, hospital): _____
Any issues at birth: _____
7. Does child have any allergies (food, medication, animals, etc)? If yes, what does the reaction look like?

8. Medication name & use (include dosing, dispensing, & refill information):

9. Explain status of child(ren)'s immunizations: ☐ up-to-date
☐ other _____
10. How is child doing in general with eating, drinking, sleeping and just in general?

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11. Explain family's status as related to health insurance:

☐ Medicaid ☐ Health Choice ☐ Private ☐ None

12. Explain any medical issues for family members: ☐ N/A

13. Explain any mental health and/or substance abuse issues for family members: ☐ N/A

14. Explain any educational issues / challenges facing family members: ☐ N/A

15. Explain the need for any child in the family under the age of 3 to be referred to CDSA in cases in which the social worker has determined the need for a referral or in cases in which item S6 on the Family Strengths and Needs Assessment is scored a "1" or a "3" (Need) **OR** describe any ongoing services already in place: ☐ N/A

16. Discuss environmental/safety factors.

a. Safe sleeping arrangements for infants discussed with family (for more information see [Safe Sleeping Arrangements](#)): ☐ YES ☐ NO ☐ N/A

b. Fire safety plan discussed with family: ☐ YES ☐ NO

c. Firearms safely stored (as per [GS 14-315.1](#)): ☐ YES ☐ NO

d. Functioning smoke detectors in home verified: ☐ YES ☐ NO

17. As a result of the information above, this worker took / needs to take the following action:

☐ See Narrative ☐ N/A:

VII. COLLATERAL CONTACTS

<u>Name</u>	<u>Contact Information</u>	<u>Type of Collateral</u> (CPS Referral, SW Determined/Required, Parent Provided)

Other social service / child welfare agencies contacted for information on household members that have resided elsewhere within North Carolina and/or outside of North Carolina: ☐ YES ☐ NO ☐ N/A

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VIII. ONGOING CASE CONTACTS

1. Date: _____

2. Name / Relationship: _____

3. Method of contact: ☐ phone call ☐ home visit (provide address if other than family address in narrative) ☐ office visit ☐ school visit ☐ other: _____

4. Narrative

1. Date: _____

2. Name / Relationship: _____

3. Method of contact: ☐ phone call ☐ home visit (provide address if other than family address in narrative) ☐ office visit ☐ school visit ☐ other: _____

4. Narrative

1. Date: _____

2. Name / Relationship: _____

3. Method of contact: ☐ phone call ☐ home visit (provide address if other than family address in narrative) ☐ office visit ☐ school visit ☐ other: _____

4. Narrative

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IX. JUVENILE PETITION (☐ N/A for this section)

1. Was a juvenile petition filed in relation to this case? ☐ YES ☐ NO
Was non-secure custody assumed? ☐ YES ☐ NO

2. Placement of the child(ren):

X. STRUCTURED DECISION-MAKING TOOLS

(Please verify by checking that following tools have been completed, discussed with family, and are placed in the case file)

☐ [DSS-5231](#) North Carolina Safety Assessment (if case is being closed with no further action there must be a Safety Assessment with a Safe finding).

☐ [DSS-5230](#) North Carolina SDM[®] Family Risk Assessment of Child Abuse / Neglect

☐ [DSS-5229](#) North Carolina Family Assessment of Strengths and Needs (required if case is "Substantiated" or found "Services Needed")

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XI. Two-Level Review Staffing and Case Decision Summary:**Children**

<u>NAME</u>	<u>AGE</u>	<u>CASE DECISION FOR EACH CHILD</u>
1.		<input type="checkbox"/> S (enter maltreatment finding(s)) <input type="checkbox"/> U <input type="checkbox"/> SN <input type="checkbox"/> SR <input type="checkbox"/> SNR <input type="checkbox"/> SP
2.		<input type="checkbox"/> S (enter maltreatment finding(s)) <input type="checkbox"/> U <input type="checkbox"/> SN <input type="checkbox"/> SR <input type="checkbox"/> SNR <input type="checkbox"/> SP
3.		<input type="checkbox"/> S (enter maltreatment finding(s)) <input type="checkbox"/> U <input type="checkbox"/> SN <input type="checkbox"/> SR <input type="checkbox"/> SNR <input type="checkbox"/> SP
4.		<input type="checkbox"/> S (enter maltreatment finding(s)) <input type="checkbox"/> U <input type="checkbox"/> SN <input type="checkbox"/> SR <input type="checkbox"/> SNR <input type="checkbox"/> SP
5.		<input type="checkbox"/> S (enter maltreatment finding(s)) <input type="checkbox"/> U <input type="checkbox"/> SN <input type="checkbox"/> SR <input type="checkbox"/> SNR <input type="checkbox"/> SP
6.		<input type="checkbox"/> S (enter maltreatment finding(s)) <input type="checkbox"/> U <input type="checkbox"/> SN <input type="checkbox"/> SR <input type="checkbox"/> SNR <input type="checkbox"/> SP

Parents / Caretakers

Parent / Guardian / Custodian / Caretaker / Agency / Foster Home / Group Care / Institution	Relationship to Child	Perpetrator
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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Case Decision Summary

Document the factual information regarding the findings as they relate to the allegations of abuse, neglect, and/or dependency, including behaviorally specific information regarding the frequency and severity of maltreatment, safety issues, and future risk of harm. If maltreatment reportedly occurred to a child(ren) by an out-of-home placement provider, answer as if the children would be remaining in the care of that provider.

Give rationale for both “yes” and “no” answers to the following questions.

1. Has the maltreatment occurred with frequency and/or is the maltreatment severe?
☐ Yes ☐ No
2. Are there current safety issues that indicate the child(ren) is likely to be in immediate danger of serious harm?
☐ Yes ☐ No
(Note: If the child(ren) is separated from his/her parents or access is restricted and that separation/restriction continues to be necessary due to safety issues, then this question must be answered “yes”, and legal action must be pursued.)
3. Are there significant assessed risk factors that are likely to result in serious harm to the child(ren) in the foreseeable future?
☐ Yes ☐ No
4. Is the child in need of CPS In-home Services or Out-of-home Services (answer “yes” if the caretaker’s protective capacity is insufficient to provide adequate protection and “no” if the family’s protective capacity is sufficient to provide adequate protection)?
☐ Yes ☐ No

Rationale for Case Decision & Disposition:

Assessment completed within the specified timeframe: ☐ YES ☐ NO If no, explain:

Family notified of the delay in making case decision: ☐ YES ☐ NO Document the discussion here or in narrative: _____

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Disposition of Case

Case closed (date): _____ Transferred to: _____ County (date) _____

Case transferred to CPS In-home Services (date): _____

Case transferred to CPS Out-of-home Services (date): _____

Case transferred to Voluntary Services (date): _____

(Investigation Assessments only)

☐ **The perpetrator is a candidate for placement on the RIL.**

(if so all required letters must be placed in the record and delivered as policy requires.)

Staffing

Names of others present for staffing:

Name of CPR contact (if applicable):

Social worker signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

☐ 5104 completed and submitted

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X. Initial Family Services Agreement (☐ N/A for this section)*This section must be completed for cases that continue to In-Home or Out-of-Home Services***Initial Family Services Agreement**

(Not used for Group Care or Institutional Assessments but may be used for licensed family foster home and kinship care providers that are receiving continued CPS services as caretakers to children in their home.)

This agreement identifies the behavioral needs and activities to be addressed by the CPS In-home or Out-of-home Family Services Agreement and until the In-home or Out-of-home Family Services Agreement is developed.

Identify behaviors and needs that affect the child(ren)'s present safety or put the child(ren) at risk of future harm.

Identify goals / activities that will be included in the In-Home or Out-of-Home Agreement.

Identify activities that will ensure child(ren) safety until development of the In-Home or Out-of-Home Agreement.

SIGNATURES (Received and Reviewed)

Child's Parent or Legal Guardian: X	Date Signed:	Child's Parent or Legal Guardian: X	Date Signed:
Child's Parent or Legal Guardian: X	Date Signed:	CPS Social Worker: X	Date Signed:

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Licensing authority notified for CPS assessments involving out-of-home placements: *(Note: The appropriate licensing agency must be notified at the beginning of a CPS Assessment involving an out-of-home placement, as well as at the time of the case decision.)*

☐ NCD CD ☐ NCD SS ☐ NCD HSR ☐ OTHER: _____

Recommendations for the Division of Child Development (DCD), Division of Social Services (DSS), or Division of Health Services Regulation (DHSR) Utilize the Notification of CPS Case Decision ([DSS-5282](#)) to notify the appropriate licensing agency of the case decision information. Identify the recommendations for child care licensing issues to DCD. For children placed in DSS or DHSR licensed foster homes / facilities, identify the recommendations discussed with the involved counties and their Children's Program Representative(s) prior to case decision.
